CITY OF MESA CHOICE HEALTH PLAN
Enrollment Workbook
2011 Summary of Benefits

2011 Open Enrollment starts October 25 and ends November 5, 2010

Open Enrollment changes are effective 1/1/2011

For Open Enrollment Instructions, *(click here)*

WHAT'S INSIDE

Contents

The information in this workbook provides general information on programs and summaries of health benefits offered to City of Mesa members. All information is subject to change and is not a guarantee of benefits.

MESA CHOICE HEALTH PLAN
Enrollment Workbook
2011 Benefits Package

All benefits described in this summary of benefits document are for general information only. The Plan Document (***click here***) describes in detail the benefits covered under the plan.

OPEN ENROLLMENT

Benefits eligible employees can make changes to their current health plan options for the coming year during open enrollment. The annual Open Enrollment period allows employees to reevaluate current benefits and decide if a change should be made. Employees may add, delete, or change coverage or dependents once each year during open enrollment.

Open Enrollment begins October 25 and ends on November 5, 2010 at 6:00 P.M. The online system will be closed until October 25.

Who needs to participate in open enrollment?

- **All full-time and part-time employees** eligible for City plan benefits, whether currently enrolled or not.
- **Retirees** who wish to make changes to their health plans.
- **COBRA** participants who wish to make changes to their health plans.
- **EVERYONE** who wants to participate in our satisfaction survey (See below for more information)

Members who do not re-enroll will be defaulted to single coverage on the Choice PPO (Medical), Dental Choice, and Basic Vision plans; opportunities to enroll in or make changes to Supplemental Life, Short Term Disability, and/or Flexible Spending will also be lost.

REMEMBER: Currently enrolled employees who do not make any changes to benefit selections and/or change who is covered during the Open Enrollment period or within 31 days of a change in status must wait until the next year's open enrollment to make a change.

MID YEAR CHANGES

Change in status is the only time currently enrolled employees can change their coverage, including Flexible Spending Account deductions, during the year, other than open enrollment. Any time life circumstances change, **the employee is responsible** for making appropriate benefits enrollment changes within 31 days of the qualifying event. These changes in status include:

- Marriage
- Divorce
- Birth, adoption or legal custody of a child
- Dependent no longer eligible under the plan due to age
- Death of dependent (spouse or child)
- Spouse loses or gains coverage eligibility due to change in employment
- Spouse's open enrollment period

Employees must notify the Benefits office within 31 calendar days of the date of the change for dependents to be added to or deleted from coverage.

NEW HIRES

New employees may choose the date their coverage will begin from three options: the employee's start date; the first of the month following the start date; or the first of the month following the first full month of employment. New employees may choose from the array of benefits described in this folder, but must meet enrollment deadlines as set forth here.

CHANGING ENROLLMENTS IN CITY OF MESA BENEFIT PLANS

Enrolling Dependents for the First Time
Members who enroll in family Coverage and whose eligible dependents have never been enrolled in one of the City-sponsored plans before MUST submit copies of the following documents, as applicable, to the Employee Benefits Office BEFORE coverage begins:

- Marriage Certificate, if enrolling a spouse
- Birth Certificates, adoption documents or other court documentation verifying legal guardianship, if enrolling one or more children
- Natural parent's divorce decree (if applicable) and the stepchild(ren)'s birth certificate(s) if enrolling one or more stepchildren
- Proof of insurance if you or your dependents are covered under another health insurance plan

Who Are My Eligible Dependents?

- Legal spouse
- Natural children and stepchildren under age 26
- Legally adopted children, foster children, or children for whom you/your spouse are a court-appointed guardian under age 26

When Can I Add or Drop a Dependent?
Our medical, dental, vision and flexible spending account (FSA) benefits are offered on a pre-tax basis. Because the IRS is giving employees a tax advantage, there are certain rules governing those benefits.

- Benefit elections can only be changed during the year if there is a Qualified Status Change
- Changes that are consistent with the status change that may be made mid-year
    - o Enrolling in or opting out of coverage
    - o Adding or removing dependents
    - o Changing your FSA election.
- Employee Benefits must be contacted within 31 days of the event or the change must wait until the next open enrollment

What Are Qualified Changes in Status?
Qualified changes in status, as identified by IRS rules, include changes that would impact your choice of coverage or level of coverage.

- Marriage
- Divorce
- Death
- Birth, adoption, or legal custody of a child
- Covered person gains or loses coverage under another plan

Although you cannot change your medical plan due to a status change, you can make most other changes.

- Enroll or disenroll dependents
- Add or terminate plans
- Change coverage levels under the plan.

IMPORTANT NOTICE REGARDING ONLINE ENROLLMENT

If you have or anticipate a status change (i.e., newborn, marriage, divorce, or adoption) that becomes effective in October or November, please contact Laura Kolsrud at (480) 644-5837 or Leslie Rogers at (480) 644-2648 in the Employee Benefits Office **before** doing your on-line enrollment. For example, if you are getting married on October 24, contact us before adding your new spouse online.

What's New For 2011

The following changes are effective January 1, 2011

Descriptions of these changes are found in the Enrollment Workbook

There are significant premium changes and several plan design changes for the 2011 plan year. Members should review these changes and all benefits described in the Enrollment Workbook before beginning online enrollment.

Premiums
Nationally and locally, health insurance costs have been increasing and are expected to continue to increase at over 10% per year. These increases combined with use of the health plans affects have resulted in an anticipated $25.6M increase in revenue requirements by 2013. The majority of this falls within 2011, but the increase has been phased in over the next three years (2011, 2012, and 2013) to ease the impact on employee premiums in 2011. For more information on the three year phase in plan, see www.mesachip.org.

Social Security Number Requirement
To comply with federal law, social security numbers for employees, their spouses, and their children ***must*** be entered in the online enrollment system to complete enrollment (***click here*** for more information).

New Short Term Disability Carrier
Mutual of Omaha will be the City's short term disability carrier for 2011. Premiums will be decreased from 2010, and employees will still have a choice of waiting periods (***click here*** for more information).

Adult Children to Age 26 Eligible for Coverage
- Children up to age 26 may be covered under the medical, dental, vision, and medical flexible spending account (FSA) plans
  - Married or unmarried
  - No requirement to reside with employee/retiree
  - Student status or religious mission not required
- There is a one-time special open enrollment for children who were not previously eligible and are under 26
  - October 25 – November 26, 2010
  - Until November 5, enrollments can be made online; after that, paper forms must be completed

Changes in Maximum Benefits Limits Under the Medical Plan
The lifetime maximum benefit has been eliminated. There is now an *annual* maximum benefit of $2 million.

No Coinsurance or Copays for Preventive Services
Under all plans, in-network preventive services, such as immunizations and well person visits, are covered at 100%, with no deductible, co-insurance, or copay *(*for services list, ***click here***).

New External Appeal Process
The appeals process will include outside medical review of claims and pre-authorizations that are appealed.

Allowable Costs to be Applied to Out of Network Costs
Allowable costs for out-of-network services will be determined based on regional criteria. Members who choose out of network providers will be responsible for the increased deductible and coinsurance, as well as the amount charged by the out of network provider that is greater than the allowable cost.

Changes to 2011 Plan Document
There will be several changes in the 2011 plan, which will be posted on mesachip.org.

Changes to the Flexible Spending Account
In accordance with the Health Care Reform bill, OTC drugs and medicines require a Physician prescription in order to be reimbursed from the Health FSA account. The physician prescription must be submitted each and every time the OTC drug or medicine is claimed for reimbursement under the Health FSA.

Open Enrollment Instructions

Open Enrollment begins October 25 and ends on November 5, 2010 at 6:00 P.M. The online system will be closed until October 25.

IMPORTANT!!! READ THIS BEFORE YOU BEGIN THE ONLINE PROCESS

Review the workbook. Premiums are changing significantly for the 2011 plan year and there are several plan design changes, as well. These changes need to be considered by employees to make the best health plan choices for them and their families.

Employees who have or who anticipate a status change (e.g., newborn, marriage, divorce, or adoption) that becomes effective in October or November 2010, please contact the Employee Benefits Office **before** doing your on-line enrollment. Do not try to add or drop your dependents online until you have contacted either Laura Kolsrud at (480) 644-5837 or Leslie Rogers at (480) 644-2648. For example, if you are getting married on October 23, 2010, contact us before adding your new spouse online.

1. Access the Internet, and type www.mesachip.org in the web browser window.

2. Click on the "OPEN ENROLLMENT ENTER HERE" button to access the Open Enrollment System. Do ***not*** click on "Member Login."

3. In the Insured ID field, type your 5-digit ID number found on your health insurance card. If you don't have an insurance card and don't know what your Insured ID number is, contact Employee Benefits.

4. In the Password field, type the following **Initial Password** scheme:
   The first four letters of your last name* (in upper or lower case) plus the last four digits of your Social Security Number (SSN).

*If your last name contains:	Last Name Example	Your SSN is:	Your password is:
Four or more letters	JONES	987654321	JONE4321
Two or three letters	COX	987634321	COX4321
More than one name	DE LA TORRE	987654321	DE L4321 (System reads space as a character)
An apostrophe	O'MEARA	987654321	OMEA4321 (System does not read apostrophes)
A hyphen after the first 3 letters	DEL-MONTE	987654321	DEL 4321 (Substitute a space for the hyphen)

   You have five chances to enter your Insured ID and Password correctly. **After the fifth try, you will be locked out of the system.** After 10 minutes, you can attempt to login again.

5. On the next screen, follow these steps:
   a. Enter your 5-digit Insured ID (see above).
   b. Re-enter the Initial Password scheme (see Step 4)
   c. In the next box, create an entirely new password of at least six letters and numbers.
   d. Re-enter the New Password.
   e. Click the "Save Password" button.

   Write your New Password here: _____
   NOTE: This password is for the Open Enrollment system *only*, *not* your CHIP login.

6. Carefully follow the instructions for each portion of the Open Enrollment System.

7. When you complete your enrollment, print a copy of your confirmation for your records. **Please review your confirmation sheet to make sure you have enrolled correctly.**

8. Sign out when your session is complete.

Need assistance? Review "Helpful Hints for Online Enrollment" on the next page, or call us at (480) 644-2299 during business hours (M-Th, 7:00 a.m. to 6:00 p.m.).

Helpful Hints for Online Enrollment

1. Use the Action Checklist as you review the Open Enrollment/Benefits Package to mark your coverage selections before you begin the Online Enrollment process.

2. Can't get into the Open Enrollment system? Did you click on the blue button labeled, "OPEN ENROLLMENT ENTER HERE"? If you clicked on "Member Login," you are not in the right area. The CHIP Member Login is different from the Open Enrollment System Login.

3. Member ID not being accepted? Did you type in 4 digits instead of 5? The old 4-digit IDs require a leading zero. For example, if your employee ID is 1001, enter it as 01001.

4. If you enter the system for a second time, remember that you changed your password after you entered the initial password scheme. The new password is a combination of letters and numbers, at least six characters long. Did you write your new password on the Open Enrollment Instructions page in the space provided? If you did not and you can't remember what you changed your password to, use the "Change Password" link on the first screen of the Open Enrollment system.

5. Carefully follow the instructions on each portion of the Online Enrollment screens.

6. Can't print your confirmation? See if you completed both the Health Flex and Dependent Flex portions.

7. There should be a checkmark by the word, "Completed", if you have completed each portion. Even if you are not participating in the Flexible Spending Plans, you still need to accept the zero amount, 0.00, shown in both Health Flex and/or Dependent Flex. Click the "Save" button on each screen to accept the zero amount.

8. When you have entered and saved the flex amounts, and there are no "Pending" items, you have completed your enrollment. All the items should be marked, "Completed," and the "Print Confirmation" button will display. You can now print a confirmation for your records. Also make sure you have accessed and completed the sections for Short Term Disability, Life Insurance, and have added or changed your Life Insurance Beneficiary(s) if desired.

9. Going from single coverage to family coverage? Be sure to click on Family Coverage for each plan (medical, dental, vision) you wish to switch to family coverage. A new section will appear asking you to add your dependents. Going from family to single coverage? Be sure to click on Single Coverage.

10. Remember to submit any verification paperwork to the Benefits Office (click here for types of verification) no later than 6 pm on Monday, November 8, 2010. Failure to comply with this requirement may result in a change in your elected coverage.

11. Remember, Evidence of Insurability (EOI) forms for Supplemental Life increases are due no later than 6:00 pm on Monday, November 8, 2010. EOI forms submitted after this date will not be accepted, and life insurance changes will not be permitted.

12. If you have questions on any of these tips or if you are still experiencing problems with your online enrollment, please contact us at (480) 644-2299 during business hours, M-Th, 7:00 a.m. to 6:00 p.m.

Open Enrollment closes promptly on Friday, November 5, 2010, at 6:00 p.m.!

One time special open enrollment for children who were not previously eligible and are under 26 will close on November 26, 2010.

WE WANT TO KNOW!

In an effort to offer the most comprehensive benefits package possible, we are requesting feedback from you, our customers and our plan members, regarding your overall benefits package, and the service you receive from our staff. At the end of the online open enrollment there will be a link to our survey. We hope you will take the time to complete it and let us know how we can better serve you!

ACTION CHECKLIST

Complete this checklist before accessing the online open enrollment system.

COVERAGE OPTIONS – Check the level of coverage you want to enroll in

MEDICAL PLAN OPTIONS (*Click here* for medical coverage and premium information)

Choice PPO – 80/20 Plan	**Full Time Premiums**
☐ Member Only (Single Coverage)	$ 30.50 per paycheck
☐ Member and Family (Family Coverage)	$108.00 per paycheck
Copay Choice – Copay for most services	
☐ Member Only (Single Coverage)	$ 56.00 per paycheck
☐ Member and Family (Family Coverage)	$195.00 per paycheck
Choice Plus PPO – 90/10 Plan	
☐ Member Only (Single Coverage)	$197.50 per paycheck
☐ Member and Family (Family Coverage)	$409.00 per paycheck
Basic Choice PPO – 50/50 Plan	
☐ Member Only (Single Coverage)	$ 0.00 per paycheck
☐ Member and Family (Family Coverage)	$ 0.00 per paycheck

☐ **Opt Out** – Choose this option if you have other health insurance coverage, and you do not want to be covered by the City of Mesa plan. *Note: if opt out is chosen, proof of other coverage must be submitted by November 8, 2010 or you will be enrolled in the basic/preventive plans.*

DENTAL PLAN OPTIONS (*Click here* for dental coverage and premium information)

Preventative Choice – 80/20 Plan, $500 annual max., no orthodontia or other major services	
☐ Member Only (Single Coverage)	$ 0.00 per paycheck
☐ Member and Family (Family Coverage)	$ 3.00 per paycheck
Dental Choice – 80/20 Plan, $1200 annual max., no orthodontia	
☐ Member Only (Single Coverage)	$ 4.75 per paycheck
☐ Member and Family (Family Coverage)	$ 17.00 per paycheck
Dental Choice Plus – 80/20 Plan, $1500 annual max., orthodontia for children under age 19	
☐ Member Only (Single Coverage)	$ 12.25 per paycheck
☐ Member and Family (Family Coverage)	$ 57.00 per paycheck

☐ **Opt Out** –if you have other dental insurance and don't want to be covered by a City of Mesa plan

VISION PLAN OPTIONS (*Click here* for vision coverage and premium information)

Basic Vision – annual exam, glasses/contacts every 24 months	
☐ Member Only (Single Coverage)	$ .26 per paycheck
☐ Member and Family (Family Coverage)	$ 3.32 per paycheck
Vision Plus - annual exam, glasses/contacts every 12 months	
☐ Member Only (Single Coverage)	$ 1.98 per paycheck
☐ Member and Family (Family Coverage	$ 8.05 per paycheck

☐ **Opt Out** –if you have other vision insurance and don't want to be covered by a City of Mesa plan

Checklist is continued on other side

DEPENDENT INFORMATION

☐ **Spouse Name** _____ date of birth _____

☐ Spouse social security number (required)_____

☐ **Child Name** _____ date of birth _____

☐ Child social security number (required)_____

☐ **Child Name** _____ date of birth _____

☐ Child social security number (required)_____

☐ **Child Name** _____ date of birth _____

☐ Child social security number (required)_____

☐ **Child Name** _____ date of birth _____

☐ Child social security number (required) _____

DOCUMENTATION REQUIRED FOR NEW DEPENDENTS OR A CHANGE IN STATUS

☐ **Add Spouse** – marriage certificate
☐ **Add child** – birth certificate; foster, adoption, or legal custody papers
☐ **Add stepchild** – birth certificate and copy of natural parent's divorce decree
☐ **Delete spouse** due to divorce – copy of divorce decree
☐ **Delete stepchildren** due to divorce - copy of divorce decree
☐ **Proof of insurance/**insurance card for dependents covered under another health insurance plan

NOTE: If you have or anticipate a status change (e.g., newborn, marriage, divorce, or adoption) that becomes effective in October or November 2009, please contact Laura Kolsrud at (480) 644-5837 or Leslie Rogers at (480) 644-2648 ***before*** *doing your on-line enrollment.*

FLEXIBLE SPENDING ACCOUNT (FSA) (*Click here* for health care and dependent FSA information)

☐ **Health Care** Flexible Spending Account **Annual** Election _____(max. $3,000)
☐ **Dependent/Child Care** Flexible Spending Account **Annual** Election _____(max. $5,000)

SHORT TERM DISABILITY (*Click here* for short term disability coverage and premium information)

☐ 14 Day Elimination (Waiting Period)
☐ 29 Day Elimination (Waiting Period)
☐ 44 Day Elimination (Waiting Period)

SUPPLEMENTAL LIFE INSURANCE (*Click here* for supplemental life coverage and premium information)

☐ Employee (increments of $10,000, max. $300,000) _____

☐ Spouse (increments of $10,000, max. $300,000) _____

☐ Child(ren) ($2,500, $5,000, $7,500, or $10,000) _____

NOTE: enrollments may be subject to medical underwriting and submittal of insurability Forms.

Mesa Choice Health Plan Highlights 2011

	CHOICE PPO PLAN 80/20		CHOICE PLUS PPO PLAN 90/10		BASIC CHOICE PLAN 50/50		COPAY CHOICE	
Medical Services	**In-Network PPO & Par Providers**	**Out-of-Network**	**In-Network PPO & Par Providers**	**Out-of-Network**	**In-Network PPO Providers Only**	**Out-of - Network**	**In-Network PPO Providers Only**	**Out-of-Network**
Deductible per calendar year	$300 per person; $900 per family	$1000 per person; $3000 per family	$200 per person; $600 per family	$1000 per person; $3000 per family	$550 per person; $1650 per family	$1000 per person; $3000 per family	None	$1000 per person; $3000 per family
Hospital Services	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$100 copay OP; $200 copay IP	After deductible, 60%
Physician & Health Care Practitioner Services	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	$20 copay for sick OV, all other 50% after deductible	After deductible, 25%	$20 copay	After deductible, 60%
Chiropractic Manipulations – 25/calendar year	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$20 copay	After deductible, 60%
Rehabilitation Services	Rehabilitation Services include physical therapy, occupational therapy, and speech therapy							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$20 copay	After deductible, 60%
X-Ray, Diagnostic	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	No deductible, 100%	After deductible, 60%
Emergency Room	After deductible, 80%	After deductible, 80%	After deductible, 90%	After deductible, 90%	After deductible, 50%	After deductible, 50%	$100 copay, ($200 copay if admitted)	$100 copay, ($200 copay if admitted)
Urgent Care Facility	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$50 copay	After deductible, 60%
Durable Medical Equipment (DME)	Includes DME rentals and purchases. DME over $1000 requires precertification through American Health Group.							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$20 copay	After deductible, 60%
Foot Orthotics	Limited coverage for molded shoe orthotics prescribed and customized by a physician. Charges subject to appropriate deductibles, coinsurances and copays based on plan selected. $500 maximum payable per calendar year.							
	After deductible, 80%	Not Covered	After deductible, 90%	Not Covered	After deductible, 50%	Not Covered	$20 copay	Not Covered
Well Child Care and Immunizations	In network preventive immunizations as recommended by federal guidelines are payable at 100%, no deductible, copay or coinsurance. No maximum.							
	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Out of Pocket Maximum	$2000 per person	None	$1000 per person	None	$5000 per person	None	None	None

*This chart is a **summary** of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health Plan Document available at www.mesachip.org or from Employee Benefits.

Mesa Choice Health Plan Highlights (continued) 2011

	CHOICE PPO PLAN 80/20		CHOICE PLUS PPO PLAN 90/10		BASIC CHOICE PLAN 50/50		COPAY CHOICE	
Medical Services	**In-Network PPO & Par Providers**	**Out-of-Network**	**In-Network PPO & Par Providers**	**Out-of-Network**	**In-Network PPO Providers Only**	**Out-of-Network**	**In-Network PPO Providers Only**	**Out-of-Network**
Well Adult Care	Services include well man and well woman services, office visits, pap smears, mammograms, PSA, fecal occult tests, routine physical exams, lab tests, chest x-ray, immunizations, colon cancer screening, and routine EKG. 100%, no maximum.							
	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Routine Colonoscopy for Members Age 50+	Covered at 100% of in-network costs once every 10 years. Payable benefits include professional fees, facility fees, and pathology fees. Member MUST use in-network BCBSAZ providers (HealthSmart for out-of-state members). This benefit is not subject to deductible or the Well Adult Care maximum.							
	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Voluntary Sterilization	Includes vasectomies, tubal ligations & other voluntary (non-medically necessary) sterilization procedures. **Note:** Procedure must be performed by a BCBS in-network provider to be considered.							
	After deductible, 50%	Not Covered	After deductible, 50%	Not Covered	After deductible, 50%	Not Covered	No deductible, 50%	Not Covered
Allergy Services (testing, physician visits)	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$20 copay	After deductible, 60%
Allergy Services (injections only)	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$5 copay	After deductible, 60%
Allergy Services (Injections with office visit)	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$20 copay	After deductible, 60%
Allergy Services with no copay (i.e., serum)	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	No copay	After deductible, 60%
Alternative Health Care (Acupuncturists, Naturopaths, Homeopaths)	After deductible, 80% up to $1000/year	After deductible, 60% up to $1000/year	After deductible, 90% with no annual max	After deductible, 70% with no annual max	Not Covered	Not Covered	Not Covered	Not Covered
Behavioral/ Mental Health Office Visits	Includes visits with psychiatrist, psychologist, or other mental health provider; counseling sessions & psychological testing. Mental health visits apply to annual out of pocket maximum.							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$20 copay	After deductible, 60%

*This chart is a **summary** of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health Plan Document available at www.mesachip.org or from Employee Benefits.

Prescription Plan Highlights 2011

Prescription drug benefits are available through the Plan's prescription drug network, Medco. For locations of the network pharmacies or information on which types of drugs are covered *(**click here**)*, contact Medco at 1(800)711-0917 or visit their website at www.medco.com.

Generic Drugs
If a generic drug is available and the member or physician refuses substitution to generic

- The member will pay the appropriate percentage or copay PLUS
- The difference in cost between the generic and brand name drug

Certain Maintenance Medications

- After the third refill at retail
  - Medco may send the member a letter recommending that maintenance medications be filled through the Mail Order Pharmacy
  - Members who do not want to use the Mail Order Pharmacy for these medications will pay double the Retail copay and the coinsurance will increase by 5%
  - Minimum and Maximum copays will also be increased

Choice, Basic, and Choice Plus Plans

- Brand name drugs for which there is no generic equivalent will be subject to the appropriate brand name coinsurance
- These drugs will not be payable at the Generic rate.

Prescription Drugs Covered Under this Plan

- Most drugs, including injectable and specialty medications, are covered
- Some drugs require prior authorization. Members who have questions about whether specific drugs are covered should contact Medco at (800) 711-0917
- Members should purchase all prescriptions, especially injectable and specialty medications,through Medco whenever possible

Generic Medications for $4 per Month

- Many retail pharmacies offer 30 day supplies of generics for $4 and $10 for 90 days
- These pharmacies include **Wal-mart, Target, Fry's and Basha's**
- We highly recommend you take advantage of these low-cost prescriptions whenever possible
- The cost of these discounted prescriptions **IS NOT** reimbursable through the Employee Benefit Trust Fund, using them will save you and the Fund money

No Coverage for Non-Network Retail Pharmacies

- Prescriptions filled at out-of-network; non-participating pharmacies must be paid for at the time of purchase
- The drug receipt and claim form must be mailed to the Medco Prescription Drug Program.
- Reimbursement is based on what would have been charged by a participating pharmacy, less the applicable retail coinsurance or copay for the plan
- Claim forms are available at www.medco.com

For detailed information on prescription drug coverage refer to the City of Mesa Plan Document at www.mesachip.org.

Note: All City of Mesa Prescription Drug Plans are considered Creditable with Medicare Part D. The Notice of Creditable Coverage *(**click here**)* is on mesachip.org

MESA PRESCRIPTION BENEFIT 2011				
Choice and Choice Plus Plans	**Annual Deductible per Person**	**Generic**	**Formulary Brand****	**Non-Formulary Brand****
RETAIL – Up to 30-day Supply				
Member Pays	$50.00	20%	25%	40%
Minimum Copay per Rx		$5.00	$25.00	$35.00
Maximum Copays per Rx		$50.00	$100.00	$100.00
Maintenance Meds* not filled by Mail-Member Pays	$50.00	25%	30%	45%
Increased Minimum Copay		$10.00	$50.00	$80.00
Increased Maximum Copay		$100.00	$200.00	$200.00
*Some Maintenance Medications not subject to increases. Check with Medco for more information				
MAIL ORDER – Up to 90-Day Supply				
Member Pays	$ 0.00	20%	25%	40%
Minimum Copay per Rx		$10.00	$50.00	$80.00
Maximum Copays per Rx		$100.00	$200.00	$200.00
** Medications with no generic alternative are covered as Formulary or Non-Formulary Brand				

Copay Choice Plan	Generic	Formulary Brand**	Non-Formulary Brand**
RETAIL – Up to 30-Day Supply			
Member Pays	$15.00	$35.00	$65.00
Maintenance Meds* not filled by Mail: Mbr Pays	$30.00	$70.00	$130.00
* Some Maintenance Medications not subject to increases. Check with Medco for more information			
MAIL ORDER – Up to 90-Day Supply			
Member Pays	$30.00	$70.00	$130.00
** Medications with no generic alternative are covered as Formulary or Non-Formulary Brand			

Basic Choice Plan	Annual Deductible per Person	Generic	Formulary Brand**	Non-Formulary Brand**
RETAIL – Up to 30-day Supply				
Member Pays	$250.00	20%	25%	40%
Minimum Copay per Rx		$5.00	$25.00	$35.00
Maximum Copays per Rx		$50.00	$100.00	$200.00
Maintenance Meds* not filled by Mail: Mbr Pays	$250.00	25%	30%	45%
Increased Min Copay		$10.00	$50.00	$80.00
Increased Max Copay		$100.00	$200.00	$400.00
* Some Maintenance Medications not subject to increases. Check with Medco for more information				
MAIL ORDER – Up to 90-Day Supply				
Member Pays	$250.00	20%	25%	40%
Minimum Copay per Rx		$10.00	$50.00	$80.00
Maximum Copays per Rx		$100.00	$200.00	$300.00
** Medications with no generic alternative are covered as Formulary or Non-Formulary Brand				

Mesa Choice Dental Plan 2011

The Dental Plans available under the Mesa Choice Plan are self-insured and self-administered. You may choose any dental care provider. There are no in-network or out-of-network provisions under these plans. Claims are processed by the City of Mesa Benefits office.

Members have three plans from which to choose based upon their individual and family needs. The dental plans are:

- **Preventative Choice Plan** – Provides coverage for preventative services and limited restorative care (basic restorative care only). Orthodontia is NOT covered**.**
- **Dental Choice Plan** – Provides preventative, basic, and major restorative coverage. Orthodontia is NOT covered.
- **Dental Choice Plus Plan** – Provides additional coverage, INCLUDING orthodontia for dependent children under age 19. (No adult orthodontia coverage.)

Dental Premiums
Premiums for the three dental plans have been determined based upon the value of the individual plan. Premiums are deducted one month ahead on a pre-tax basis.

Non-Covered Dental Services
As with the medical plan, there are certain services that are not covered under any of the dental plans. They include:

- Expenses exceeding the Allowed amount (see below)
- Orthodontia for children under age 19 that started ***before*** benefits began with the City of Mesa
- Analgesia, sedation, hypnosis, nitrous oxide and/or related services provided for apprehension or anxiety, except when medically necessary
- Cosmetic services, including but not limited to veneers and facings
- Drugs and medicines (these may be covered under the prescription plan)
- Duplication of dental services by another provider
- Home use supplies, such as dental rinses, toothpaste, fluoride, etc.
- Dental implants
- Athletic mouth guards
- Oral hygiene or dietary instructions
- Orthognathic services
- Periodontal splinting
- Sealants for adults

For more detailed information about services that are not covered, please refer to the Plan Document found at www.mesachip.org or contact Employee Benefits at (480) 644-2299.

Allowed Charges
ALL dental charges that are submitted to the Benefits Office are compared to a schedule of allowed charges before they are processed.

- When the billed charge for services is higher than the amount allowed for the provider's location (by zip code), benefits will be paid based on the allowed amount
- The member is responsible for paying the difference between the billed charge and the allowed amount
- To avoid paying more than the allowed charges for dental services, members should have providers submit a Predetermination of Dental Benefits form to the Employee Benefits Office **BEFORE** services are rendered
  - The Benefits Office will indicate any costs over the allowed charges
  - Deductibles and coinsurance will be determined based upon the provider's estimate of costs

MESA CHOICE DENTAL PLAN HIGHLIGHTS 2011			
DENTAL SERVICES	**PREVENTATIVE CHOICE PLAN**	**DENTAL CHOICE PLAN**	**DENTAL CHOICE PLUS PLAN**
Deductible per calendar year	$100/person; $300/family Applies to restorative care only	$100/person; $300/family Applies to restorative care only	$100/person; $300/family Applies to restorative care only
Preventative visits Include exam, tooth cleaning, bitewing x-rays; Full mouth/panoramic x-rays limited to once every 36 months. (Excludes periodontal cleanings & services)	Not subject to deductible 100%	Not subject to deductible 100%	Not subject to deductible 100%
Basic Restorative (sealants*, fluoride, fillings, extractions) *Coverage limited to dependent children under age 19 only	After deductible, 80%	After deductible, 80%	After deductible, 80%
Major Restorative (crowns, bridges, root canals, dentures, oral surgery, periodontal, & endodontic)	Not Covered	After deductible, 80%	After deductible, 80%
Orthodontia** **Coverage applies only to dependent children under age 19	Not Covered	Not Covered	No Deductible, 80% Coverage, $1200 Maximum Payable/Year $2400 Maximum Payable Lifetime
Annual Maximum Payable for Dental Services	$500 per person	$1200 per person	$1500 per person
This chart is a summary of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health Plan Document (***click here***), available at www.mesachip.org or from Employee Benefits.			

Mesa Choice Vision Plan 2011

Vision care benefits are provided by Vision Service Plan (VSP). The City offers its members two types of plans:

- **Basic Vision** – Offers basic coverage at a nominal cost.
- **Vision Plus** – Offers additional coverage for a higher monthly premium.

Select a Participating Provider at www.vsp.com or call 1-800-877-7195.

VSP IN-NETWORK PLAN HIGHLIGHTS		
	BASIC VISION PLAN 12/24/24	**VISION PLUS PLAN 12/12/12**
Comprehensive Vision Exam	$10 copay, once every 12 months	$10 copay, once every 12 months
Materials	$10 copay, once every 24 months	$10 copay, once every 12 months
The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.		
Pair of Lenses for Eyeglasses • Standard single vision • Standard lined bifocal • Standard lined trifocal	Once every 24 months Covered in Full Covered in Full Covered in Full	Once every 12 months Covered in Full Covered in Full Covered in Full
Lens Options • Standard Scratch Coating • Tints • Polycarbonate Lenses* • UV Coating • Basic Progressive Lenses *Covered in Full for Children under 18	 Available at a discount Available at a discount Available at a discount Available at a discount Available at a discount	 Available at a discount Available at a discount Available at a discount Available at a discount Available at a discount
Lens options not covered by the plan may be available at a discount		
Eyeglass Frames	Once every 24 months receive a $130 retail frame allowance PLUS 20% discount off amounts over the retail allowance.	Once every 12 months receive a $130 retail frame allowance PLUS 20% discount off amounts over the retail allowance.
Contact Lenses in lieu of Eyeglasses (Lenses & Frames)	Once every 24 months	Once every 12 months
Covered in full elective contact lenses • $200 Allowance in lieu of lenses and frames • Member receives 15% discount off doctor's professional fees for Contact Lens fitting and evaluation	$200 allowance once every 24 months. Fitting/evaluation is offered at a 15% discount. If a member chooses a contact lens not currently part of the Contact Lens Care Program, they have the flexibility to use their elective contact lens allowance any way they choose. The allowance can go toward contact lens services and contact lenses. Members will always receive 15% off all contact lens services from their VSP doctor. VSP covered contact lenses may vary by provider.	$200 allowance once every 12 months. Fitting/evaluation is offered at a 15% discount. If a member chooses a contact lens not currently part of the Contact Lens Care Program, they have the flexibility to use their elective contact lens allowance any way they choose. The allowance can go toward contact lens services and contact lenses. Members will always receive 15% off all contact lens services from their VSP doctor. VSP covered contact lenses may vary by provider.
Medically Necessary Contacts Lenses • $250 Allowance	Applies to individuals who cannot wear eyeglasses because of a medical condition, allergy, etc. Covered once every 24 months	Applies to individuals who cannot wear eyeglasses because of a medical condition, allergy, etc. Covered once every 12 months
Refractive Eye Surgery- Member may receive approximately 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities. Many other services are available at discounted rates. Check with your vision care provider or the Vision Service Plan website at www.vsp.com.		

VSP OUT-OF-NETWORK PLAN HIGHLIGHTS

SERVICE	AMOUNT
Exam	
• Optometrist	Up to $40
• Ophthalmologist	Up to $40
Contact Lenses (in lieu of eyeglasses)	
• Elective	Up to $200
• Necessary	Up to $250

SERVICE	AMOUNT
Lenses	
• Single Vision	Up to $40
• Bifocal	Up to $60
• Trifocal	Up to $80
• Lenticular	Up to $100
Frames	Up to $45

TO FILE AN OUT OF NETWORK CLAIM:
Submit an itemized receipt with the covered member's ID number, name, address, phone number, patient's date of birth and relationship to member to the following address:

VSP
Attn: Out-of-Network Claims
PO Box 997105
Sacramento, CA 95899-7105

Be sure to write on your receipt "City of Mesa Vision Plan"

Limitations and Exclusions

This plan is designed to cover eye examinations and corrective eyewear. Benefits are payable only for expenses incurred while the group and individual member's coverage is in force.

The following services and materials are not covered under the Vision Service Plan

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (i.e. refractive error less than +/- 0.50 diopter power)
- Two pairs of glasses instead of bifocals
- Medical or surgical treatment of the eyes
- Replacement of lenses and frames furnished under this program, except at the normal intervals when services are available

The following items are not covered under the VSP Plan contact lens coverage

- Corneal Refractive Therapy (CRT) or Orthokeratology
- Replacement of lost or damaged lenses
- Insurance policies or service agreements
- Plano lenses (i.e. refractive error less than +/- 0.50 diopter power)
- Artistically painted lenses
- Additional office visits associated with contact lens pathology
- Contact lens modification, polishing or cleaning

MONTHLY PREMIUMS FOR FULL-TIME EMPLOYEES

2011 PREMIUMS **2010 PREMIUMS**

CHOICE PPO PLAN (80/20)

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$429.00	$368.00	$61.00	$30.50	$30.50	$15.25
Family	$1,217.00	$1,001.00	$216.00	$108.00	$168.00	$84.00

CHOICE PLUS PLAN (90/10)

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$763.00	$368.00	$395.00	$197.50	$225.50	$112.75
Family	$1,819.00	$1,001.00	$818.00	$409.00	$578.00	$289.00

BASIC CHOICE PLAN (50/50)

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$368.00	$368.00	$0.00	$0.00	$0.00	$0.00
Family	$1,001.00	$1,001.00	$0.00	$0.00	$0.00	$0.00

COPAY CHOICE PLAN

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$480.00	$368.00	$112.00	$56.00	$80.50	$40.25
Family	$1,391.00	$1,001.00	$390.00	$195.00	$328.00	$164.00

DENTAL CHOICE PLAN

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$95.00	$85.50	$9.50	$4.75	$9.50	$4.75
Family	$170.00	$136.00	$34.00	$17.00	$34.00	$17.00

DENTAL CHOICE PLUS PLAN

Single	$110.00	$85.50	$24.50	$12.25	$24.50	$12.25
Family	$250.00	$136.00	$114.00	$57.00	$114.00	$57.00

PREVENTIVE CHOICE PLAN

Single	$85.50	$85.50	$0.00	$0.00	$0.00	$0.00
Family	$142.00	$136.00	$6.00	$3.00	$6.00	$3.00

BASIC VISION PLAN

	Total Premium	City Contribution	Employee Contribution	Per Paycheck	Employee Contribution	Per Paycheck
Single	$4.86	$4.35	$0.51	$0.26	$.51	$.26
Family	$13.42	$6.79	$6.63	$3.32	$6.63	$3.32

VISION PLUS PLAN

	Total Premium	City Contribution	Employee Contribution	Per Paycheck	Employee Contribution	Per Paycheck
Single	$8.30	$4.35	$3.95	$1.98	$3.95	$1.98
Family	$22.88	$6.79	$16.09	$8.05	$16.09	$8.05

***24 Paychecks**

MONTHLY PREMIUMS FOR PART-TIME EMPLOYEES

Rates for 2011 **2010 Rates**

CHOICE PPO PLAN (80/20)

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$429.00	$233.00	$196.00	$98.00	$152.50	$76.25
Family	$1217.00	$678.00	$539.00	$269.50	$420.00	$210.00

CHOICE PLUS PLAN (90/10)

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$763.00	$233.00	$530.00	$265.00	$347.50	$173.75
Family	$1,819.00	$678.00	$1,141.00	$570.50	$830.00	$415.00

BASIC CHOICE PLAN (50/50)

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$368.00	$233.00	$135.00	$67.50	$122.00	$61.00
Family	$1,001.00	$678.00	$323.00	$161.50	$252.00	$126.00

COPAY CHOICE PLAN

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$480.00	$233.00	$247.00	$123.50	$202.50	$101.25
Family	$1,391.00	$678.00	$713.00	$356.50	$580.00	$290.00

DENTAL CHOICE PLAN

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$95.00	$47.50	$47.50	$23.75	$47.50	$23.75
Family	$170.00	$85.00	$85.00	$42.50	$85.00	$42.50

DENTAL CHOICE PLUS PLAN

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$110.00	$47.50	$62.50	$31.25	$62.50	$31.25
Family	$250.00	$85.00	$165.00	$82.50	$165.00	$82.50

PREVENTATIVE CHOICE PLAN

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$85.50	$47.50	$38.00	$19.00	$38.00	$19.00
Family	$142.00	$85.00	$57.00	$28.50	$57.00	$28.50

BASIC VISION PLAN

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$4.86	$4.35	$0.51	$0.26	$0.51	$0.26
Family	$13.42	$6.79	$6.63	$3.32	$6.63	$3.32

VISION PLAN PLUS

	Total Premium	City Contribution	Employee Contribution	Per Paycheck*	Employee Contribution	Per Paycheck*
Single	$8.30	$4.35	$3.95	$1.98	$3.95	$1.98
Family	$22.88	$6.79	$16.09	$8.05	$16.09	$8.05

*24 Paychecks

MONTHLY PREMIUMS FOR COBRA PARTICIPANTS

Rates for 2011 **2010 Rates**

CHOICE PPO PLAN (80/20)

	Total Premium	Total Premium
Single	$437.58 ($429.00 + $8.58)	$311.10
Family	$1,241.34 ($1,217.00 + $24.34)	$856.80

CHOICE PLUS PLAN (90/10)

	Total Premium	Total Premium
Single	$778.26 ($763.00 + $15.26)	$510.00
Family	$1,855.38 ($1,819.00 + $36.38)	$1,275.00

BASIC CHOICE PLAN (50/50)

	Total Premium	Total Premium
Single	$375.36 ($368.00 + $7.36)	$279.99
Family	$1,021.02 ($1,001.00 + $20.02)	$685.44

COPAY CHOICE PLAN

	Total Premium	Total Premium
Single	$489.60 ($480.00 + $9.60)	$362.10
Family	$1,418.82 ($1,391.00 + $27.82)	$1,020.00

DENTAL CHOICE PLAN

	Total Premium	Total Premium
Single	$96.90 ($95.00 + $1.90)	$96.90
Family	$173.40 ($170.00 + $3.40)	$173.40

DENTAL CHOICE PLUS PLAN

	Total Premium	Total Premium
Single	$112.20 ($110.00 + $2.20)	$112.20
Family	$255.00 ($250.00 + $5.00)	$255.00

PREVENTATIVE CHOICE PLAN

	Total Premium	Total Premium
Single	$87.21 ($85.50 + $1.71)	$87.21
Family	$144.84 ($142.00 + $2.84)	$144.84

BASIC VISION PLAN

	Total Premium	Total Premium
Single	$4.96 ($4.86 + $.10)	$4.96
Family	$13.69 ($13.42 + $.27)	$13.69

VISION PLAN PLUS

	Total Premium	Total Premium
Single	$8.47 ($8.30+ $.17)	$8.47
Family	$23.34 ($22.88 + $.46)	$23.34

Choosing the Best Plan for You and Your Family

How do I know which plan to choose?
Although the City of Mesa Benefits Office cannot recommend a specific plan, this section includes some information for you to consider as you make your health insurance plan decisions.

Member premium costs
- Which of the plans will fit best within your family's budget?
    - Do you have the immediate financial resources to handle the deductible?
- Keep in mind that health insurance premiums are deducted on a pre-tax basis
    - The premium does not equal a reduction in your take home pay

Health care expense history
- What was your out of pocket expense during the last calendar year?
- How much are you actually USING your benefits?
- How much do you think you will use them in the future?
- What is your network utilization like? Does it have to be that way?

Do the math!
- Add how much you pay in premiums
- Add how much you pay for medical out of pocket expenses
- Add how much you pay for prescription medication out of pocket expenses
- Add naturopath or homeopath expenses

Compare
- How much are you paying under your current plan?
- How much would you paying under the other current plans?

Consider
- Are you enrolled in the most expensive plan just because it's convenient or because it gives you a feeling of security?
- How likely are you to spend more than the out-of-pocket or annual maximums?
- Are you or one of your family members quite ill with a chronic condition?
- Have you, or has someone in your family made numerous visits to the hospital?
- Are you, or is someone in your family, likely to need surgery, or perhaps a crown or root canal, in the coming year?
- Is one of the children going to need of braces for their teeth?
- Do you want to change vision plans so that you can have more or less frequent benefits?

Use Available Resources
- The Explanation of Benefits forms that we send to your home every time we process a claim
- Look up your claims online at www.mesachip.org
- Pharmacy receipts from both the local retail and mail order pharmacies
- Get a list of your prescriptions online at www.medco.com
- The excel worksheet (**click here**) that can be printed and used as a hard copy or copied and used online.
- The comparisons for medical, dental, and vision plan benefits (***click here***)
- The contact information for the plans to answer coverage questions (***click here***)

Getting the Best Bang for Your Health Care Buck

How to Maximize Your Benefits and Save Money for Yourself and the Employee Benefit Trust

Choose In-Network PPO providers

- Make sure **ALL** providers involved in your care are in the Blue Cross Blue Shield of Arizona PPO network if you live in Arizona
- If you live outside of Arizona, use HealthSmart PPO network providers
- Ensure that **ALL** providers involved (such as the surgeon, anesthesiologist, assistant surgeons, and the healthcare facility) are in-network providers

Use the Prescription Plan Wisely

- Choose generic medications whenever possible. Not only will you get a better benefit, but it will also be less expensive for the plan
- Use the mail order pharmacy for your medications you take regularly
  - We receive a greater discount on each drug from Medco, our pharmacy benefit manager
  - The dispensing fee is also less– 65 cents per prescription vs. up to $3.50 at the retail pharmacy
  - The mail order pharmacy is easy to use and saves everybody money
- Ask your doctor about possible alternatives to the more expensive brand name medications
- Do cost comparisons. If there is a less expensive medication that will give you the same results, use it.

Enroll in or increase your contributions to the Health Care Flexible Spending Account (FSA) in 2011

- Health Care Flexible Spending Accounts are a great way to reduce your tax liability on health care-related expenses
- An FSA acts like a no-interest loan, because you can receive the money up to your elected amount when the expense is incurred, even if it hasn't been deducted yet
- Expenses such as medical and dental deductibles, copays, and coinsurances are eligible for reimbursement

Other City Benefit Plans

Flexible Spending Accounts offer members the opportunity to set aside ***pre-tax*** dollars through deductions from their paychecks to pay for certain eligible health care and/or dependent care (child or elder care) expenses (***click here***). ***Click here*** *for a worksheet to help you determine your eligible medical costs.*

Basic Life Insurance for full-time employees is at no cost to them. For most employees, the benefit is equal to their annual salary rounded up to the nearest $1,000 (***click here***).

Employee Assistance Program (EAP) provides professional short term confidential counseling at no charge to the member. There are a maximum of eight visits per person per issue per year (***click here***).

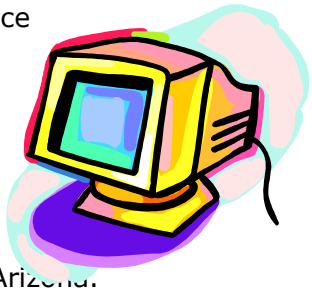
Supplemental Life Insurance offers employees the opportunity to purchase additional life insurance coverage for themselves, their spouse, and/or dependent children (***click here***).

Short Term Disability is a benefit designed to protect a portion of your salary when you cannot work because of an accident, illness, or pregnancy (***click here***).

Important Phone Numbers

Employee Benefits	(480) 644-2299	Benefit Information and Questions
American Health Group	(602) 265-3800 or (800) 847-7605	Precertification
EAP Preferred	(602) 264-4600	Employee Assistance Program
Medco	(800) 711-0917	Prescription Drug Program
Vision Service Plan	(800) 877-7195	Vision Benefits
CIGNA Life Insurance*	(800) 732-1603	Supplemental Life*
Mutual of Omaha		Short Term Disability Benefits
HealthSmart PPO	(800) 687-0500 Option 8	Out-of-State Network (for members outside of Arizona only)

*Please call Employee Benefits for any questions regarding Supplemental Life insurance



Important Websites

www.azblue.com	To find an in-network medical provider in Arizona.
www.medco.com	To find information about your prescription drug benefit, locate a pharmacy, and order prescriptions from the home delivery pharmacy.
www.mesachip.org	To view the City of Mesa Plan Document, get benefit forms, and your benefit information and claim history.
www.eappreferred.com	To get information on EAP counseling and referrals to mental health providers.
www.healthsmart.com	To find providers in out-of-state directory or for customer service (for insureds living outside of Arizona only).
www.vsp.com	To find a Vision Service Plan provider and other coverage information

Mesa Choice Medical Plan Information

Our entire health insurance program is self-insured and self-administered, with Blue Cross Blue Shield of Arizona (BCBSAZ) continuing as our network provider. Claims are sent to and processed by the City of Mesa Employee Benefits Office.

Members may choose between four different medical plans depending upon their individual needs for a comparison of coverage under the plans). Please refer to the City of Mesa Plan Document, available at www.mesachip.org for detailed descriptions of covered and non-covered services.

Medical Premiums
Premiums for the four medical plans have been determined based upon the value of the individual plan. Premiums are deducted on a pre-tax basis, which means your premium payments/deductions are made from your paychecks before federal, state, and FICA taxes are calculated. Therefore, your taxable income is lowered and you pay less income tax.

Full-time and part-time employees' insurance premiums are deducted from the first two paychecks one month in advance of coverage. Whenever there is a third paycheck in a month, no premiums are deducted.

For the 2011 monthly premiums for full-time employees (***click here***); for part-time employees **(*click here*);** and for COBRA participants, (***click here***) year.

In Network Coverage
It is important that members choose in-network providers in order to get the best benefit. When an individual uses a provider who is in the Blue Cross Blue Shield of Arizona network, the health plan and the member receive discounts. To use the network benefits under the plan most effectively:

- Check the Blue Cross Blue Shield of Arizona, ***azblue.com***, for participating providers
- Make sure **ALL** providers involved in your care (such as the surgeon, anesthesiologists, assistant surgeons, and the healthcare facility) are in-network providers.

Annual Out of Pocket Maximum (In-Network)

- The total amount a member must pay, not including deductibles, copays, and prescription drug costs before the health plan covers expenses at 100%
- Each time an in-network claim is processed by the health plan, coinsurance paid by the member is applied to the out of pocket maximum amount
- When the in-network out-of-pocket maximum is reached, covered medical claims will be paid at 100% for the rest of the calendar year

Out-of-Network Coverage
The Medical Plan offers out-of-network coverage for those members who choose to use a provider who is not in the Blue Cross Blue Shield of Arizona network. However, in every plan, out of pocket costs for using non-network providers are substantially more for the member and for the Employee Benefit Trust.

- **Choice PPO Plan: 60/40** for out of network coverage after a $1,000 deductible per person ($3,000 family)
- **Choice Plus PPO Plan: 70/30** for out of network coverage after a $1,000 deductible per person ($3,000 family)
- **Basic Choice Plan: 25/75** which offers catastrophic out of network coverage after a $1,000 deductible per person ($3,000 family)
- **Copay Choice Plan: 60/40** for out of network coverage after a $1,000 deductible per person ($3,000 family)

In addition, there are other increased costs for using out-of-network providers:

- **No Out-of-Pocket Maximum** - members who choose out-of-network providers will pay ***all*** deductibles and ***all*** coinsurances, regardless of total cost
- **Coinsurance will be calculated based on allowable costs** for the out of network service.
- Members will pay any costs billed by out of network providers above the allowable cost in addition to their coinsurance *(**click here** for more information on allowable costs)*.

- **Out-of-network emergency room visits** will not be paid in network if not medically necessary
- **Any out-of-network post-emergency follow up care will be covered at out-of-network rates** unless the out-of-network care is medically necessary
- **Out-of-network services will not be paid at the in-network rate** unless the City's independent medical review has determined that there is not an appropriate provider in the network, based on medical necessity

Coverage for Emergency Services Outside Network Area

All plans provide coverage for emergency services incurred while traveling outside the network area. Emergency services will be covered when that level of care is required due to medical necessity.

- The initial emergency visit will be covered as in-network if emergency services were medically necessary
- All follow-up visits and services must be provided by a BCBSAZ provider or facility to be paid as in-network in Arizona
- Follow up care for members who live outside Arizona and require emergency services must be provided by a provider who is contracted with HealthSmart (or in some instances, Beech Street) to be considered in-network

Out-of-State Plan Members
Members who reside or have dependents who reside outside of Arizona for six months or more are eligible to receive in-network benefits by using providers contracted with HealthSmart, or in some cases, Beech Street (***click here*** for details).

Precertification and Utilization Review/Case Management

Precertification

- Required under all City of Mesa Medical Plans for certain covered services
- Ensures that hospitalizations, surgeries, and other procedures are medically necessary
- The physician's office will contact the plan on your behalf to pre-certify required services
- **Members are responsible for making sure services have been pre-certified. Failure to pre-certify will increase the amount members have to pay**
- Some procedures that require precertification:
    - All elective non-emergency admissions, except for birth of a baby (not including post-natal)
    - All elective admissions to specialized facilities, including outpatient surgical centers, hospice, skilled nursing facilities, and sub-acute care facilities
    - All admissions to inpatient or day treatment rehab facilities for both medical and mental health services
    - Colonoscopies, except those covered under the Routine Colonoscopy Benefit
    - Other invasive diagnostic tests
    - Sleep studies
    - Durable Medical Equipment with a cost of $1000 or more;
    - **Emergency hospital admissions within 48 hours after admission**

Utilization (or Concurrent) Review/Case Management

- Ensures that continuation of medical services is medically necessary
- Coordinates member care with other health care providers, such as home health agencies, durable medical equipment vendors, and others
- May also assist with discharge planning and advising medical providers of various options available under the plan

Non-Covered Services
Services that are not covered under the City of Mesa Medical Plans include, but are not limited to:

- Cosmetic surgery or related expenses
- Fertility treatment, except limited services available under the Choice Plus PPO Plan
- Health club memberships
- Massage therapy, except when performed by a physical therapist or chiropractor
- Medications not approved by the FDA
- Nutritional supplements and/or vitamins (except prenatal vitamins)
- Services that are experimental and/or investigational in nature
- Vision services, except exams and lenses required following cataract surgery
- Weight management programs. For more detailed information about services that are not covered, please contact Employee Benefits at (480) 644-2299 or refer to the Plan Document (***click here***) found at www.mesachip.org.

Other Insurance Coverage

- Member who is or whose dependents are covered by another health insurance policy must submit a copy of the insurance card from the other carrier or other documentation to the Employee Benefits Office
- If other coverage has been terminated, documentation of the termination date must be submitted
- Certain rules determine which plan is primary (i.e., which plan pays first)
- The City of Mesa plan does not coordinate benefits with primary plans that have co-pays.
- For assistance with determining which of your insurance carriers is primary, please contact Employee Benefits at (480) 644-2299.

Your Insurance Card and ID Number

Remember: your medical card is combined with your prescription drug card and comes to you from Medco

- Always take your healthcare ID card with you when visiting a healthcare provider office
- The 5-digit ID number found on your Medco insurance card is the medical plan Insured ID number and should be used when filling out forms at a healthcare provider's office
- **Claims submitted with incorrect information may be denied**
- **Please order replacement cards through the Medco website (*click here*)**

Instructions for Locating a Blue Cross Blue Shield of Arizona Provider

Members enrolled in any of the Choice Medical Plans may choose a Blue Cross Blue Shield of Arizona contracted provider. Provider discounts vary based upon the provider's contract with BCBSAZ.

Using the Blue Cross Blue Shield of Arizona Website
Follow the instructions below to locate a medical provider in the Blue Cross Blue Shield network.

1. On the web go to the Blue Cross Blue Shield of Arizona website at www.azblue.com
2. A Guest page will appear. Click on "Search the Provider Directory" link.
3. On the "Health & Dental Provider Directory" page, under the ID card sample that says "Acme Company," click on the "Search the Provider Directory" link.
4. You will see three tabs entitled "Providers", "Facilities" and "Urgent Care". Select the tab that applies to your search.
5. Under "Search by Network", click on the drop down arrow and select "PPO".
6. You can then enter your address, provider name or specialty to define your search. Once done, click on the "Search" button.

The website is updated monthly by BCBSAZ, listing any new providers, or removing those who have terminated recently.

Medical Coverage for Out-of-State Members

The City of Mesa is contracted with HealthSmart PPO* to provide an out-of-state network for those health plan members who live outside the State of Arizona to help them and the Employee Benefit Trust save money on members' health care needs.

The HealthSmart PPO* network includes a variety of providers throughout the United States, including hospitals, urgent care centers, family practice doctors and specialists. This network is only for those covered persons who regularly live outside Arizona. **It is not for members who normally reside in Arizona who are traveling outside the state.**

If a member or an eligible dependent is moving out-of-state, the Benefits Office should be notified so the member or dependent can be enrolled in HealthSmart.

For out-of-state members who use a HealthSmart PPO* contracted provider, services will be processed as in-network for the plan selected. For example, if a member is enrolled in the Choice Plus (90/10) plan, services rendered by a HealthSmart provider will first be subject to a $200 per person annual deductible, then paid at 90%. The member will be responsible for paying this deductible and the 10% coinsurance.

If a non-network provider is used by a Choice Plus member, services will be processed as out-of-network (subject to a $1000 deductible, then paid at 70%). However, if the member has another insurance as the primary carrier, covered services will be paid as **in-network**. See below.

If you are having a surgical procedure, hospitalization, receiving durable medical equipment over $1000, or receiving home health care, these types of services still need to be precertified by American Health Group at (602) 265-3800 or 1 (800) 847-7605.

If the City of Mesa is your primary or only carrier, present your HealthSmart PPO* card to the provider at the time or your appointment. If you did not receive a card, please contact the Employee Benefits Office at (480) 644-2299 or via e-mail at benefits.info@cityfomesa.org. Please give the provider your 5-digit ID number as the Insured ID-number. The provider needs to send your claim to: HealthSmart, PO Box 53010, Lubbock, TX 79453-3010.

If the City of Mesa is your secondary carrier, inform the provider that you have primary insurance. After the primary insurance has processed the claim, send the itemized bill with the primary carrier's Explanation of Benefits to: City of Mesa Employee Benefits, PO Box 1818, San Leandro, CA 94577. Providers should still call Employee Benefits at (480) 644-2299 to verify coverage, if necessary.

Finding a HealthSmart Provider (Out-of-State Residents Only)

- Go to www.healthsmart.com.
- Click on "Members" located at the top of the screen
- Click on "Provider Lookup" located at the top of the screen.
- Click on the"Find" button in the New Provider Lookup box.
- Click in the small box located in the lower left corner of the Disclaimer box stating you acknowledge and have read the disclaimer. Then click the "Continue" button.
- In box 1 (Choose your Network Plan), click in the circle next to HealthSmart Preferred Care.
- In box 2 (Enter Location), enter either your city and state or zip code.
- In box 3 (Choose Provider Options), select your search criteria. Then click on the "Find" button.

If you have questions or problems with finding a provider, please contact HealthSmart directly at 1(800)687-0500, option 8 or extension 2502. Please be sure to ask for Policy CM002 providers.

**In some states, HealthSmart PPO has also contracted with BeechStreet PPO to provide expanded network services. Members living in Arkansas, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, and Tennessee can only use HealthSmart PPO (not Beech Street) providers to be considered as in-network. Beech Street PPO does not contract with HealthSmart PPO in these states.*

Mesa Choice Flex Plan

The Mesa Choice Flex Plan offers employees the opportunity to set aside pre-tax dollars from their paychecks to pay for certain eligible health care and/or dependent care (child or elder care) expenses that would normally be paid out of your own pocket. When you enroll in the flexible spending account program, you reduce your tax liability by reducing your taxable income.

New for 2011
In accordance with the Health Care Reform bill, OTC drugs and medicines require a Physician prescription in order to be reimbursed from the Health FSA account. The physician prescription must be submitted each and every time the OTC drug or medicine is claimed for reimbursement under the Health FSA.

Health Flexible Spending Account
The Health Flex plan allows you to set aside up to $3,000 in 2011 to pay for eligible health care expenses that are not covered by your insurance. These expenses must be incurred by you or a qualified dependent. These include:

- Deductibles
- Coinsurance
- Copayments
- Certain items not covered by insurance

Dependent Care Flexible Spending Account
The Dependent Care Flex Plan allows you to set aside up to a maximum of $5,000 per married couple or single adult in 2011 to pay for eligible child or elder care services that are needed so you and your spouse (if applicable) can work. Tuition for educational expenses (whether private or public) for children in kindergarten to age 13 is not eligible for reimbursement. Once you incur expenses for certain qualifying childcare expenses, you can submit those receipts to Employee Benefits for reimbursement from this account. The claims will be reviewed for eligibility and accuracy. Reimbursements made from this account will be equal to the amount of the claim, but not more than the amount currently in your Dependent Care Account. **This account is for day care expenses ONLY. You cannot claim dependent medical/dental expenses on the Dependent Care Flex Account**.

Dependent Care arrangements, which qualify include:

- A Dependent (Day) Care Center, provided it complies with applicable state and local laws if care is provided by the facility for more than six individuals;
- An education institution for pre-school children.
- For school-age children (Kindergarten through age 12), only expenses for before & after school care are eligible; tuition fees do not apply.
- An "individual" who provides care inside or outside your home who is not your child under age 19 or anyone you claim as a dependent for federal tax purposes (i.e., spouse).

Reimbursement for Expenses
If you receive reimbursement for an expense from one of the flexible spending accounts, you cannot claim that expense as a deduction or take a federal income tax credit on your personal income tax return.

Claims may be submitted for reimbursement up to 90 days after the end of a calendar year in which you are enrolled. The deadline to submit FSA claims for expenses incurred January 1, 2011 through December 31, 2011, will be March 31, 2012, by 6:00 p.m.

NOTE: When enrolling in the Flexible Spending Plan(s) for the first time, you should estimate your eligible expenses **carefully**: Any money left in your account after the reimbursement deadline will be forfeited and deposited into the Employee Benefit Trust.

Employee Assistance Program (EAP)

The City of Mesa offers an Employee Assistance Program (EAP) to employees and their family members that provides professional and confidential counseling and referral services at no charge to the member. There is a maximum of eight visits per person per issue each year. This program applies to mental health and substance abuse counseling services only. Retirees and their family members are not eligible to use EAP services.

The Employee Assistance Program is an employer-paid benefit. Counseling is short-term and completely confidential. All staff are state licensed or certified and have a masters or doctorate degree.

All employees are eligible to use EAP services immediately upon becoming employed by the City of Mesa, regardless of their full-time or part-time status. Family members are also eligible and do not have to be enrolled in one of the City's medical plans in order to make an appointment with one of the counselors.

Our provider for this service is EAP Preferred. They have several locations throughout Maricopa County.

To schedule an appointment, call between 8:00 A.M. – 5:00 P.M., Monday through Friday.

Maricopa County: (602) 264-4600, press 2
Outside Maricopa County: Toll Free 1(800) 327-3517, press 2

After Hours and Weekend Emergencies:

Maricopa County: (602) 264-4600, press 5
Outside Maricopa County: Toll Free 1(800) 327-3517, press 5

Additional locations available outside of Maricopa County: 1(800) 327-3517

Website: www.eappreferred.com

Behavioral Health benefits for extended behavioral health care are available to individuals enrolled in one of the Mesa Choice Plans.

EAP Preferred
(602) 264-4600
www.eappreferred.com

Mesa Choice Disability Programs - Short Term Disability

Voluntary Short Term Disability (STD) is a benefit designed to protect a portion of your salary when you cannot work because of an accident, illness, or pregnancy. Standard Life Insurance administers the short term disability benefits program. This program does not cover accidents incurred on the job. **EFFECTIVE JANUARY 1, 2011, THE CITY OF MESA WILL HAVE A NEW STD CARRIER – MUTUAL OF OMAHA**.

You may enroll in STD when you are hired or during the annual open enrollment period. If you are a new enrollee or making a change to your waiting period, you can enroll on the Open Enrollment Online system at www.mesachip.org. You may choose between the 14 day, 29 day, or 44 day waiting period.

If you are currently enrolled, you do not need to re-apply, only if you are changing benefit waiting periods. Members who are currently enrolled in STD will still need to confirm their coverage when completing their online enrollment.

If you do not presently have STD coverage and wish to enroll you will be subject to a pre-existing exclusion for the first 6 months from your STD effective date (1/1/2011).

This means if you file a claim during the first 6 months of coverage, no disability benefit will be paid if the disability is caused by, contributed to, or resulted from a pre-existing condition.

A pre-existing condition means any injury or sickness for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicine prescribed or taken in the 3 months prior to the day you become insured under the STD policy.

Please note:
If you currently have Short Term Disability (STD) coverage, and have been enrolled for 6 months or more, you will receive credit for STD participation and the pre-existing exclusion will not pertain to you.

Salary protection under this policy is limited to 6 months of paid benefits after the waiting period. During the waiting period, you may use accrued leave as outlined in the Personnel Rules. All sick and vacation accruals will be frozen while you are receiving the STD benefit.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of *active work* as an eligible employee.

Benefit Amount

After your waiting period, you will receive 66 2/3% of your base salary at the time of disability. This income is non-taxable since you pay tax on your monthly premiums.

Plan Maximum Weekly Benefit: $2000 Plan Minimum Weekly Benefit: $25

The three short term disability plan options available are:

- Plan Option 1: 15-day benefit waiting period. Monthly cost is $.61 per $10 of benefit.
- Plan Option 2: 30-day benefit waiting period. Monthly cost is $.33 per $10 of benefit.
- Plan Option 3: 44-day benefit waiting period. Monthly cost is $.27 per $10 of benefit.

How to File a Claim – effective January 1, 2011

An employee can submit a claim to Mutual of Omaha three different ways:

- Mutual of Omaha Website
- Telephone intake
- Paper claim form

It is important that you complete the STD form as soon as you become disabled as it may take several days or weeks for Mutual of Omaha to process your application.

During your waiting period, your application will be reviewed by Mutual of Omaha to determine if you are eligible to receive STD payments. You may use sick leave, vacation, comp time, or donated leave to cover your absence during the waiting period.

In some cases, the review process may take longer than your waiting period, resulting in a delay in payment of your STD benefit. Should this occur, Payroll will place you on dock status. Contact Jayson Vowell in Payroll at (480) 644-2389 for further information on this occurrence.

You are not required to make premium payments for your STD coverage during your period of disability. If a premium payment is deducted from your paycheck in error, it will be returned to you. **You are responsible** for paying the employee's portion of your health insurance premiums during your STD benefit period. You will receive an invoice for payment from Finance for premiums due.

Please contact Mutual of Omaha and your timekeeper **immediately** if you return to work earlier than anticipated. Otherwise, you may create an overpayment from Mutual of Omaha that will need to be repaid.

Please remember to contact Stacie Peyton in Human Resources at (480) 644-5762 to obtain and complete the Family Medical Leave Act (FMLA) paperwork related to your disability. Submitting this paperwork provides you with job protection and maintains your health insurance premiums at the same level as when you are working for up to 12 weeks.

If you have any Short Term Disability questions, please call Jeanne Young in Employee Benefits at (480) 644-2660.

Mesa Choice Disability Programs Long Term Disability

The City of Mesa provides Long Term Disability coverage to all full-time and part-time employees participating in the Arizona State Retirement System (ASRS). A third party insurance company under the guidance of ASRS administers this benefit. The administrator is Sedgwick CMS. The cost of this program is shared between the participant and the City of Mesa.

Additionally, the City of Mesa provides Long Term Disability coverage to sworn firefighters, sworn police officers and city council members. A third party insurance company (CIGNA) under the guidance of the City of Mesa administers this benefit. The cost of this program is paid in full by the City of Mesa.

Program Definitions

The definition of disability is determined by the LTD carrier and is defined as follows:

- During the first thirty (30) months of a disability, including a six-month waiting period, you are considered Totally Disabled if you are under the care of a licensed physician and are unable to perform all of the essential duties of the job you held when you became disabled.
- After you have received benefits for twenty-four (24) continuous months, you are considered Totally Disabled if you are under the care of a licensed physician and are unable to perform any work for compensation or gain for which you are reasonably qualified by education, training or experience.

The waiting period as determined by the LTD carrier is defined as follows:

- The Benefits Waiting Period will be 180 days of continuous Disability. A period of Disability will be considered continuous even if you return to a full-time work in your regular job for up to a total of 10 days for ASRS members and 30 days for PSPRS members during the Benefit Waiting Period. The Benefit Waiting Period will be extended by the number of days you temporarily returned to work.

Program Benefits

- ASRS MEMBERS – the policy covers 66.67% of your base salary after the 180 day waiting period, less any other compensation that you may receive.
- PSPRS MEMBERS – the policy cover 60% of your base salary after the 180 day waiting period, less any other compensation that you may receive.

⇨ **ATTENTION PSPRS MEMBERS**: No LTD application is necessary. You can call CIGNA at 1-800-362-4462 and CIGNA will take your LTD information by phone. You can also fill out a claim form online at www.CIGNA.com.

If you have any Long Term Disability questions, please call Jeanne Young in Employee Benefits at (480) 644-2660.

Mesa Choice Life Insurance Programs
City Funded Life and AD&D Coverage

The City provides several Life Insurance policies for employees, including Basic Life Insurance, Accidental Death and Dismemberment Coverage, and Commuter Life Insurance. These programs are fully funded by the City of Mesa.

Basic Life Insurance
Basic Life Insurance is underwritten by CIGNA Life Insurance to full-time employees at no cost to them. For most employees, the benefit is equal to your annual salary rounded up to the nearest $1,000. When you were hired, you were asked to designate a beneficiary for this policy. We highly recommend you **verify your beneficiary every few years**, but especially when you experience a major life event, such as marriage, divorce, birth or death of a family member. You may check or change your beneficiary information using the online enrollment system.

Accidental Death and Dismemberment
Like the Basic Life Insurance policy, this coverage will be provided by CIGNA Life Insurance to full-time employees at no cost to them. The benefit is also equal to your annual salary rounded up to the nearest $1,000. The beneficiary for this policy is the same individual that you designated for your Basic Life Insurance.

Commuter Life Insurance
Provided through Hartford Life Insurance, this policy provides a $200,000 death benefit to your beneficiary in the event you are killed as a result of an accident that occurs while you are commuting to or from work using your normal route. This policy does not cover travel by aircraft.

Mesa Choice Life Insurance Programs
Supplemental Life

Supplemental (or Voluntary) Life Insurance offers employees the opportunity to enroll in additional life insurance coverage for themselves, or a spouse, and/or dependent children. Coverage for employees and a spouse is available in $10,000 increments up to a total of $300,000. Premiums for this coverage are the employee's responsibility and are paid through payroll deduction. The City does not contribute to this coverage, which is provided by CIGNA Life Insurance.

To add or increase coverage during Open Enrollment, use the Online Open Enrollment system. **If no changes are being made, no re-application is required. However, during Online Open Enrollment employees need to confirm current life insurance selections.**

If an employee is not currently enrolled in this coverage, or is covered for less than the Guaranteed Issue of $100,000, the employee may enroll in either $10,000 or $20,000 of additional coverage without having to complete a Cigna Change Form.

- For example, if an employee is currently enrolled in $50,000 of coverage, that coverage may be increased to $70,000 with no additional forms.

All increases in spouse life insurance coverage require a completed Change Form.

Increases to a spouse's coverage for 2011 require an underwriting and approval process by the carrier. Please print and complete the Cigna Change Form if prompted, and return it to the Benefits Office no later than 6pm on November 8. 2010. Remember Employee Benefits is closed on Fridays and therefore is closed on the final day of Open Enrollment (November 5).

This coverage may be portable should a covered employee terminate employment with, or retire from, the City of Mesa. Please refer to the Life Insurance Certificate of Coverage for more information.

The premiums shown below are per $1,000 of coverage.
Employee & Spouse Monthly Premiums

Age Band	Employee & Spouse	Age Band	Employee & Spouse
Under 20	$0.06	50-54	$0.48
20-24	$0.06	55-59	$0.79
25-29	$0.06	60-64	$1.11
30-34	$0.07	65-69	$1.93
35-39	$0.09	70-74	$2.99
40-44	$0.17	75-79	$4.28
45-49	$0.35	80+	$8.27

Dependent Children Monthly Premiums – premium is based upon the amount of coverage elected regardless of the number of dependent children covered. Dependent children are covered from ages 6 months to 19 years and from 19 to 23 years if a full-time student at an accredited school or on a religious excursion. **The maximum benefit for a dependent child who is less than 6 months old is $500.**

Child Benefit	Total Monthly Cost
$2,500	$0.40
$5,000	$0.80
$7,500	$1.20
$10,000	$1.60

Have Ineligible Dependents? Remove them from your Coverage if:

1. The Child is NOT a full-time student or on a religious excursion after age 19 years thru 23 years.
2. If the employee divorces from a covered spouse.

If an employee continues to pay premiums on an ineligible dependent, premiums paid WILL NOT be refunded.

Mesa Choice Health Plan
Part-Time Employee Benefits

Part-time employees who are working in a benefits-eligible position may enroll in the following benefit programs:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Supplemental Life Insurance

The coverage levels for these benefit programs are the same as for full-time employees. Please refer to the descriptions found earlier in this workbook.

Part-time benefits are only available to those employees who are working in benefits-eligible positions as defined in Management Policy 320 and determined by the individual department managers.

Benefit-eligible part-time employees must meet a six-month waiting period before benefits may begin. If you have not completed your waiting period, the Benefits Office will notify you when you are eligible to make your elections. If, however, you have already completed your waiting period and have declined benefits in the past, you may enroll during this open enrollment period.

Premiums
The City Contribution for part-time employees on the medical and dental plans is 50% of the total premium for the Choice PPO and Dental Choice Plans. For Vision, the City Contribution is the same as for full-time employees. For premiums for part-time employees who enroll in Medical, Dental, or Vision coverage *(**click here**)*.

Health insurance premiums are deducted from your payroll check one month in advance.

Supplemental Life Insurance
Part-time employees may also enroll in the Supplemental Life Insurance program (***click here*** for more information).

Affordable Care Act Changes

Children to Age 26 May be Covered Under the Plan
Individuals whose coverage ended, who were denied coverage or who were not eligible for coverage because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the City of Mesa group health plan. No coverage is extended to son-in-law, daughter-in-law, or grandchildren, except in the case of legal custody. Employees may request enrollment for such children from October 25 through November 26. Enrollment before November 6 should be on line and enrollment made after November 6 must be made using a paper enrollment form. Birth Certificates will be required if not already on file. Coverage will be effective January 1, 2011. For more information contact the Benefits Office at 480-644-2299.

No Retroactive Cancellation of Coverage
In accordance with the requirements of the Affordable Care Act, effective January 1, 2011 the plan will not retroactively cancel coverage except for non-payment of premium or in the case of fraud or intentional misrepresentation of material fact and with at least a 30-day advanced written notice for fraud or misrepresentation.

Retroactive terminations of coverage may be made for ineligibility under the requirements of the Plan Document and no advanced written notice will be required.

Annual Notification - Women's Health and Cancer Rights Act of 1998

Federal law requires the following notification: Group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive breast surgery. This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications for all stages of mastectomy, including lymphedemas.

Coverage is subject to the Plan's normal rules, including in-network co-payments or out-of-network annual deductibles and coinsurance provisions. If you have any questions about this law, including Plan benefits for mastectomies or reconstructive surgery, please contact Margie Ward, Employee Benefits Administrator at (480) 644-4421.

HIPAA – Health Insurance Portability and Accountability Act of 1996

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, requires that health plans like the City of Mesa Health Plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used

to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- PHI does not include health information contained in employment records held by the City of Mesa in its role as an employer, including but not limited to health information related to disability, work-related illness/injury, sick leave, Family or Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you or distributed to you upon enrollment in the Plan and is also available from the Employee Benefits Office or at www.mesachip.org.

Medicaid & the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.
If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243

ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 1-877-764-5437	
ARKANSAS – CHIP Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	**FLORIDA** – Medicaid Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	**MONTANA** – Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	**NEBRASKA** – Medicaid Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479 **IOWA** – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	**NEVADA** – Medicaid and CHIP Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
KANSAS – Medicaid Website: https://www.khpa.ks.gov Phone: 800-766-9012	**NEW HAMPSHIRE** – Medicaid Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570 **LOUISIANA** – Medicaid Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	**NEW JERSEY** – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557 **MASSACHUSETTS** – Medicaid and CHIP Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	**NEW MEXICO –** Medicaid and CHIP Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	**NEW YORK –** Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	**NORTH CAROLINA** – Medicaid Website: http://www.nc.gov Phone: 919-855-4100

NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493 Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Ext. 6156

Medicare Mandatory Reporting Requirement

As a health plan payor, the City of Mesa is required to comply with a number of federal laws, including HIPAA (see above) and the new Medicare Mandatory Reporting Requirement. This new requirement came about because of increased misunderstandings by providers and Medicare recipients regarding the primary/secondary relationship between Medicare and their other Group Health Plan (like those offered by the City of Mesa).

When a person becomes eligible for Medicare, either because they have reached their Medicare-eligibility age OR they have been disabled in accordance with Medicare rules, they are automatically enrolled in Medicare Part A, which covers the person under Medicare for Hospitalizations. They will also have the option of enrolling in Medicare Part B (for professional services, such as doctor visits, lab and x-ray services), and there is a monthly premium. When a person is also covered by another insurance plan, such as those offered by the City of Mesa, both the City and Medicare must determine which plan is primary (i.e. which plan pays first when services are rendered) and which plan is secondary.

Many people assume that when they become eligible for Medicare that Medicare is automatically primary. This is not necessarily the case, especially if the person is still an active employee or is the spouse of an active employee. For this reason, the Centers for Medicare and Medicaid Services (CMS) has enacted the new Medicare Mandatory Reporting Requirement—to ensure those who are enrolled in both Medicare and another group health plan understand which plan is considered their primary insurance.

To facilitate this process, CMS is requiring all health insurance payors to submit the names and social security numbers of all of their members, regardless of their age or Medicare status. They will then verify which people are enrolled in Medicare and will communicate this information to the Employee Benefits Office, so we can notify the member which insurance coverage should be considered primary. As a result of this requirement, we are required to have all plan members (employees and retirees) provide us with the social security numbers of their dependents (spouses and children). We will then communicate this information to CMS as required by federal law.

Please note this information will be kept completely confidential and private, as the City of Mesa Employee Benefits Office is bound by HIPAA to maintain the privacy of all personal health information. If you have any questions or concerns about this new requirement, please contact Margie Ward, Employee Benefits Administrator at (480) 644-4421.

Medicare Notice of Creditable Coverage

Important Notice from the City of Mesa about Prescription Drug Coverage for People with Medicare

This notice is for people with Medicare. Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with the City of Mesa and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

The City of Mesa has determined that the prescription drug coverage under the following prescription drug plan options (the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan and the Copay Choice Plan) are "creditable".

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan option(s) noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from November 15th through December 31st); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision on whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

WHY CREDITABLE COVERAGE IS IMPORTANT

(When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage. Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary

premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next November to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

Your Choices:	What you can do:	What this option means to you:
Option 1	You can select or keep your current medical and prescription drug coverage with **the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan** and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through **the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan**. • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during November 15-December 31 of each year). • As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.

Your Choices:	What you can do:	What this option means to you:
Option 2	You can select or keep your current medical and prescription drug coverage with **the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan** and also enroll in a Medicare prescription drug plan. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.	Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows: • For Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary. • For Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under **the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan.** That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number), for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Para mas información sobre sus opciones bajo la cobertura de Medicare para recetas medicas.

Revise el manual "Medicare Y Used" para información detallada sobre los planes de Medicare que ofrecen cobertura para recetas medicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben de llamar al 1-877-486-2048. Para mas información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Contact: City of Mesa, Employee Benefits Administrator
Address: 20 E. Main St., Ste 600, Mesa, AZ 85201
Phone Number: (480) 644-3009

As in all cases, the City of Mesa reserves the right to modify benefits at any time, in accordance with applicable law. This document (dated **October, 2010**) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.